MINNESOTA LIFE

ATTENDING PHYSICIAN'S STATEMENT

Group Division Claims • P.O. Box 64114 • St. Paul, MN 55164-0114 • FOR CLAIM INFORMATION CALL: Toll Free 1 800-328-9442 – MN local 651-665-3815

CLAIM NUMBER:

- ☐ Please have this form completed immediately.
- ☐ Please have this form completed on or after _____ .
- ☐ Please have this form completed on _____ or upon recovery if sooner.
- ☐ If you remain disabled beyond _____ and wish further consideration of your claim, please have this completed.

The insured is responsible for the completion of this form without expense to the Company. You may mail this form directly to the Home Office of the Company. Both sides of this form must be fully completed by the attending physician.

PATIENT'S NAME (Last, First, Middle Initial)	DATE OF BIRTH (Mo/Day/Yr)	TELEPHONE NUMBER
		( )

PRESENT ADDRESS (Street, City, State, Zip)

HISTORY

1. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT OCCURRED	2. DATE PATIENT CEASED WORK DUE TO DISABILITY	3. IS CONDITION DUE TO INJURY OR ILLNESS ARISING OUT OF PATIENT'S EMPLOYMENT? IF YES, CHECK ONE
		☐ Yes ☐ Injury ☐ No ☐ Illness

4. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? IF YES, STATE WHEN AND DESCRIBE

☐ Yes ☐ No

5. NAMES AND ADDRESSES OF OTHER TREATING PHYSICIANS

DIAGNOSIS

1. DIAGNOSIS INCLUDING ANY COMPLICATIONS FOR CURRENT CONDITION	2. PATIENT ACCOUNT/FILE NUMBER

3. SUBJECTIVE SYMPTOMS

4. OBJECTIVE FINDINGS (including current x-rays, EKG's, laboratory data and any clinical findings)

NATURE AND DATES OF SERVICE

1. DATE (Mo/Day/Yr) OF FIRST VISIT	2. DATE (Mo/Day/Yr) OF LAST VISIT	3. DATE (Mo/Day/Yr) OF NEXT VISIT	4. FREQUENCY

5. HAS PATIENT BEEN HOSPITALIZED? IF YES, GIVE DATES

☐ Yes ☐ No FROM _____ THROUGH _____

6. WAS SURGERY PERFORMED – DESCRIBE TYPE – DATE OF SURGERY

☐ Yes ☐ No

7. NAME AND ADDRESS OF HOSPITAL

8. IS THE PATIENT CURRENTLY ENROLLED IN ANY TYPE OF REHABILITATION PROGRAM	☐ Yes ☐ No	9. IF YES, WHAT TYPE OF PROGRAM	☐ CARDIAC ☐ PHYSICAL THERAPY ☐ OTHER _____

10. LIST MEDICATIONS

F. 18615 Rev. 4-1999

SEE REVERSE SIDE

CARDIAC (if applicable)

FUNCTIONAL CAPACITY (American Heart Association)

☐ CLASS 1 (No limitation) ☐ CLASS 2 (Slight limitation) ☐ CLASS 3 (Marked limitation) ☐ CLASS 4 (Complete limitation)

BLOOD PRESSURE READING

PHYSICAL IMPAIRMENT (*as defined in Federal Dictionary of Occupational Titles)

☐ Class 1 – No limitation of functional capacity; capable of heavy work. *No restrictions (0 - 10%).
☐ Class 2 – Medium manual activity* (15 - 30%).
☐ Class 3 – Slight limitation of functional capacity; capable of light work* (35 - 55%).
☐ Class 4 – Moderate limitation of functional capacity; capable of clerical/administration (sedentary*) activity (60 - 70%).
☐ Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary*) activity (75 - 100%).

IF ANY RESTRICTIONS, DESCRIBE WHAT TYPE AND HOW LONG THESE RESTRICTIONS WILL EXIST.

MENTAL/NERVOUS IMPAIRMENT (if applicable)

☐ Class 1 – Patient is able to function under stress and engage in interpersonal relations (no limitations).
☐ Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations).
☐ Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations).
☐ Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitation).
☐ Class 5 – Patient has significant loss of psychological, personal and social adjustment (severe limitations).

DESCRIBE THE BASIS FOR THE ABOVE DECISION

DO YOU FEEL THIS PATIENT IS COMPETENT TO ENDORSE AND DIRECT THE USE OF PROCEEDS THEREOF

☐ Yes ☐ No

PROGRESS

1. PATIENT HAS . . . (check one)
☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

2. IF RECOVERED, DATE (Mo/Day/Yr) RELEASED TO RETURN TO WORK

3. PATIENT IS . . . (check one)
☐ Ambulatory ☐ Bed Confined ☐ House Confined ☐ Hospital Confined

PROGNOSIS FOR REGULAR WORK

IS PATIENT DISABLED AND UNABLE TO PERFORM HIS/HER REGULAR WORK ☐ Yes ☐ No Date Released _____

DO YOU EXPECT A FUNDAMENTAL OR MARKED CHANGE IN THE FUTURE RELATING TO PATIENT'S JOB ☐ Yes - Improvement ☐ Yes - Deterioration ☐ No

IF NO, PLEASE EXPLAIN

IF IMPROVEMENT IS EXPECTED, WHEN WILL PATIENT RECOVER SUFFICIENTLY TO PERFORM DUTIES OF HIS/HER REGULAR WORK ☐ 1 MO ☐ 4-6 MO ☐ NEVER ☐ 2-3 MO ☐ OTHER _____

PATIENT IS A SUITABLE CANDIDATE FOR ☐ Trial Employment ☐ Work Hardening ☐ Job Retraining ☐ Full Time ☐ Part Time

PROGNOSIS FOR OTHER GAINFUL WORK

IS PATIENT DISABLED AND UNABLE TO PERFORM OTHER GAINFUL WORK ☐ Yes ☐ No Date Released _____

DO YOU EXPECT A FUNDAMENTAL OR MARKED CHANGE IN THE FUTURE RELATING TO OTHER GAINFUL WORK ☐ Yes - Improvement ☐ Yes - Deterioration ☐ No

IF NO, PLEASE EXPLAIN

IF IMPROVEMENT IS EXPECTED, WHEN WILL PATIENT RECOVER SUFFICIENTLY TO PERFORM DUTIES OF OTHER GAINFUL WORK ☐ 1 MO ☐ 4-6 MO ☐ NEVER ☐ 2-3 MO ☐ OTHER _____

CHECK BOX IF PATIENT IS NOT A SUITABLE CANDIDATE ☐ None

HAVE THEY REACHED MAXIMUM MEDICAL IMPROVEMENT ☐ Yes ☐ No

REMARKS

NAME OF ATTENDING PHYSICIAN (Please print) | DEGREE | TELEPHONE NUMBER ( )

PHYSICIAN'S ADDRESS (Street, City, State, Zip)

SIGNATURE OF ATTENDING PHYSICIAN | DATE SIGNED | PRINT NAME OF PERSON COMPLETING THIS FORM

X

NOTICE: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against the insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. The commission of insurance fraud may subject such person to criminal and/or civil penalties. Any insurance company or agent of an insurance company who knowingly attempts to defraud a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Division of Insurance.

Minnesota Life
P.O. Box 64114
St. Paul, MN 55164-0114